KyHealth Choices

Medicaid Commissioner's Public Forum
January 18, 2007
Highlights

Below is a short summary of the Topics and Question/Answers that were discussed during the Department of Medicaid Services (DMS) Commissioner's forum. Among some of the topics and questions addressed were Provider Creditionaling, Prior Authorization, Consumer Directed Options and the newly established Department for Aging and Independent Living.

Topics of Discussion

Newsletter/Forum - Commissioner Jennings apologized for not having a December newsletter posted due to it being submitted so close to the forum date. The commissioner stated that the newsletter would be available in February on the Department for Medicaid Services (DMS) KyHealth Choices page. The Commissioner also announced that the next forum is on March 15, 2007 at 3:00 pm.

Day to Day-Operational Issues

- ***Creditionaling issues*** – DMS and First Health are in the process of catching up on the backlog that resulted from a number of issues. Some of the issues include trouble with the KAPER-1 form since it's inception in 2005 and trouble with the fax server receiving information. DMS and First Health are continuing to work on these issues.
- ***Prior Authorization (PA) issues*** - There have been problems with obtaining PA s and PA letters. These problems have resulted from fax server and computer system issues. DMS is working with both EDS and SHPS in developing a permanent solution to these problems. Additionally, DMS is working with providers to identify and process outstanding PA s.
- ***552 issues*** – From 5/3/06 to 9/20/06 when the 552 file was sent to EDS, there was a problem with the system and the files were bypassed. From 9/20/06, there was 3800 that had to be entered in amounts. As to date, there have been 2,600 files corrected. There will be a mass adjustment for these claims and a notification letter going out to the providers informing them of the adjustment.

E-Health Summit – The Commissioner mentioned that he would be attending the first Kentucky e-Health Summit on January 19 2007. The Summit will allow state and community leaders involved in e-Health initiatives throughout Kentucky to learn more about the efforts of the Kentucky e-Health Network Board and various local health information exchange efforts. The Summit will also serve as a networking forum for individuals and organizations also seeking to further the adoption of health information technology (HIT) and health information exchange (HIE).

Eli Lilly Grant - DMS is working with Eli Lilly on a research grant to study the usage of antipsychotropic drugs for Medicaid members. Eli Lilly will pay an independent research company to come in and study the trends on drug usage and provide patient education. This research has been conducted in 25 states and has resulted in a 30% drop in drug usage. In order to participate in this research grant, DMS has submitted a State Plan Amendment (SPA) to Centers for Medicare and Medicaid Services (CMS) and are currently awaiting a decision.

Deficit Reduction Act (DRA) - DMS continues to pursue the "COMBO Model" utilizing portions of the DRA and 1915c waivers. The Basic Level of Care Plan was formally submitted to CMS on December 15, 2006. CMS has 90 days to respond. The plan includes a broader provider base including: senior Citizen Centers, and public housing authorities. The plan requires independent assessment and reassessment and includes the availability of crisis stabilization. The Expanded Plan (Level Two) will be submitted by April 30, 2007. This plan will also include crisis stabilization and will expand the service array to develop a continuum of care and focus on community services. The Expanded Level of Care will require amendments to three 1915 c waivers. A team of providers, consumers, advocates and staff will meet on January 19, 2007 to work on this plan.

Money Follows the Person Grant – In early January 2007, CMS awarded the First Tier to 17 states, which represents $888,625,631 in federal funding and 23,604 individuals transitioned out of institutional settings over the five-year demonstration period. This round of funding may be followed up with a second round in the next couple of months after clarification can be obtained on various application features in the remaining 21 States that applied. Unfortunately, Kentucky was not one of the states that received the award. The Commissioner thinks the reason why an award was not received is Kentucky was because of the requirements for rebalancing the state's long-term care system. He hopes by reviewing the denial letter from CMS and making the changes CMS suggests, Kentucky may be able to receive an award in the Second Tier.

Long Term Care Initiative - In December 2006, Governor Fletcher signed an executive order creating the Department for Aging and Independent Living (DAIL) to centralize policy coordination, services and leadership on issues related to older Kentuckians and people with physical disabilities. DAIL will focus on serving the needs and enhancing the independent living opportunities of Kentucky's elders and people with physical disabilities. DAIL will be part of the Cabinet for Health and Family Services (CHFS) and replaces the former Division for Aging Services. DAIL will continue to provide the programs and services currently available to elders and people with physical disabilities while expanding its focus to include new ventures as needs are identified.

One of the missions of the department will be to respond to the significant segment of the state's population who will want access to services, supports, advocacy and opportunities to continue to work, engage in community activities and enjoy as much independence as possible for as long as possible. To help prepare for this population, CHFS will need to establish a streamlined process and single point of entry to Medicaid and other vital programs to help make that transition as smooth and effortless as possible. This new agency will play a major role in achieving that and other goals."

Another of the department's core functions will focus on Kentuckians with physical disabilities who are currently living with and being cared for by aging parents and others. As those caregivers become unable to provide the required level of care, the department will marshal resources and tools to help people with disabilities transition to the most appropriate and least restrictive care environments for their needs.

The department also will collaborate with other cabinet and external agencies serving persons with mental health and other types of disabilities.

Consumer Directed Options (CDO) - DMS continues to work toward implementing CDO in the most efficient and effective manner possible. The Home and Community-Based Services waiver (HCB) was implemented on 9/30/06. The Supports for Community Living (SCL) Wavier was implemented on 11/30/06. The Department for Aging and Independent Living (DAIL) has created a technical assistance team to identify problems and solutions. The team met on December 19, 2006 and made initial recommendations. The recommendations were reviewed and most were adopted. DMS and DAIL are now in the process of implementing the revised procedure based on the recommendations. It is planned for the Acquired Brian Injury (ABI) waiver to be implemented February 19, 2007 with trainings on the process beginning in early February.

QUESTIONS and RESPONSES

What is the Single Point of Entry Grant? The Kentucky Aging and Disability Resource Center (ADRC) has established a comprehensive one stop resource and counseling center to create an information and referral system to assure that clients, both public and private, are informed of all choices for long term supports. Within the next year, the Pilot will create a seamless system for client access to all long-term care supports. In order to accomplish this, the Pilot will include all stakeholders; incorporate the access process into the information technology system that currently coordinates the Information and Assistance functions of the ADRC. The ADRC will assist in educating individuals about managing their own care through the new CDO for HCB and SCL waiver clients.

Some of the Comprehensive Care Centers are telling CDO individuals that they have to go though them in order to receive HCB waiver services. Is this true? No, this is not true. For more information contact the either the Division of Long Term Care at 502-564-5560 or DAIL at 564-5390.

How do we address working with an individual who is having trouble getting HCB waiver services? To address issues or concerns with the waivers, contact the Division of Long Term Care at 502-564-5560.

A parent has inquired about placing autistic child on the HCB waiver. They were told by the home health agency that the child is ineligible. Why is this so? The Home Health Agency should not automatically assume the child is ineligible just based on the diagnosis. The HCBW does not exclude medical eligibility based on diagnosis as the child may meet the criteria. It may have been a situation where the HHA went to the individual's home to start the assessment and during the process realized the child did not meet two (2) of the criteria outlined in 907 KAR 1:022.

What are the CMS timeline requirements regarding waivers (1915c, 1115-demo waiver), e.g., are there established timeframes, deadlines similar to state plan amendments? The following are indications where timeliness is emphasized in relation to 1915 (c) waivers:

1) The state Medicaid agency must submit an application to CMS for review and approval for an HCBS waiver. There is no discernable timeline for achieving this goal. Initial HCBS waivers are **approved for a three-year period, and waivers are renewed for five-year intervals**.

2) If the Secretary denies a request of the state for an extension of a waiver, any waiver in effect on the date such request is made shall remain in effect for **a period of not less than 90 days** after the date on which the Secretary denies such request (or, if the state seeks review of such determination, the date on which a final determination is made with respect to such review).

3) Each state with a waiver shall **provide to the Secretary annually**, consistent with a reasonable data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the state plan and on the health and welfare of recipients.

4) A request to the Secretary from a state for approval of a proposed state plan or plan amendment or a waiver of a requirement of this title submitted by the state pursuant to a provision of this title shall be deemed granted unless the Secretary, **within 90 days** after the date of its submission to the Secretary, either denies such request in writing or informs the state agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request.

5) After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within **90 days of such date**, denies such request.

6) No waiver may extend over a **period of longer than two years** unless the state requests continuation of such waiver, and such request shall be deemed granted unless the Secretary, **within 90 days** after the date of its submission to the secretary, either denies such request in writing or informs the state agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, **within 90 days of such date**, denies such request.

Are there any KRS addressing prior authorization (PA) timeframes, e.g., Medicaid program or health insurer must approve/deny a prior authorization request within so many hours/days? ". . . . the KRS stated that the cabinet shall promulgate regulations regarding prior authorizations".

Per Medicaid regulations:

1) There does not appear to be a set time period for response for PA requests on medications. The typical response time for a PA request on a drug is 14 hours or less if it is an urgent request and 48-72 hours for a non-emergency requests.

2) For those programs where timelines are stressed, it appears that the burden is on the provider, rather than the department.

3) **907 KAR 1:595. Model Waiver II services and payments.**

Section 5. Prior Authorization for a Service.

(1) Prior to authorizing a Model Waiver II service, the department shall ensure that:

(a) Client ventilator-dependent status is met;

(b) Service is available to meet the need of a recipient; and

(c) The service does not exceed the cost of traditional institutional ventilator care.

(2) A physician shall:

(a) Evaluate the need for continuation of service; and

(b) Submit a completed MAP-9, Prior Authorization for Health Services, and a signed plan of treatment at **least once every sixty (60) days**.

4) **907 KAR 1:479. Durable medical equipment covered benefits and reimbursement**.

Section 7 (2) If an item requires prior authorization, a supplier shall comply with the following:

(a) Submit all required documentation prior to the date of service; or

(b)1. Submit a written request within seven (7) business days to the department for prior authorization which shall include the prescriber's order; and

2. After receiving acknowledgement from the department that the prior authorization request is being processed, submit to the department a completed CMN and prior authorization form within thirty (30) business days.

5) **907 KAR 1:012. Inpatient hospital services**

Section 2. Prior Authorization. To be covered by the department:

1) Prior to a non-emergency admission, including an elective admission or a weekend admission department shall have made a determination that the non-emergency admission was:

(a) Medically necessary; and

(b) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130; and.

(2) Within seventy-two (72) hours after an emergency admission, the department shall have made a determination that the emergency admission was:

(a) Medically necessary; and

(b) Clinically appropriate pursuant to the criteria established in 907 KAR 3:130.

What about PA's and denials? Is there a process to address these?
Medicaid members are entitled to pursue a complaint against the department or request an administrative hearing with the cabinet, if denied a service, procedure, or if they believe their rights have been violated. These complaints are conducted in accordance with KRS Chapter 13B. The procedure is covered in 907 KAR 1:563."

Is there somewhere on the DMS website that issues and concerns can be addressed or is there a contact list? You may contact DMS by either using the "CHFS Listens" or "Site Review" on the CHFS's Contact page or you may email the DMS webmaster with your question or concerns. DMS will work on a contact list to post on the website in the near future.

Will a provider be able to cross-referenced by a Social Security number when the new Medicaid ID numbers are issued? Yes. On the new system, the provider will be able to use the new member ID and SSN and they will be linked together.

H***ow do you to complete the NPI paperwork recently received in the mail from DMS?*** **If you have not yet obtained your NPI and taxonomy code(s), please do so as soon as possible.** There are three ways to obtain your NPI and taxonomy code(s):

- Contact FOX Systems to obtain a paper copy of the application by calling 1-800-465-3203 or by email at customerservice@npienumerator.com
- Complete the online application at the NPPES website https://NPPES.cms.hhs.gov/NPPES/Welcome.do.
- An employed provider should contact their employer or other trusted organization that can obtain an NPI on their behalf through bulk enumeration, or Electronic File Interchange (EFI) with the provider's authorization.

Once providers obtain their NPI and taxonomy code(s), FOX Systems will issue verification. **All providers required to submit their NPI should send a copy of the FOX Systems verification to *KyHealth Choices***. A copy of the FOX Systems verification should be mailed or faxed to: *KyHealth Choices;* NPI/Taxonomy; P.O. Box 2110; Frankfort, KY 40602; Fax: 502-607-8401. For more information on submitting your NPI and taxonomy code(s), please call 1-800-639-5195.

Are providers going to be receiving a mailing regarding the new member card and how it is to be used ? There has been discussion on a mailing to Providers sometime near the end of Feb, beginning of March but nothing is for sure yet. There has been communication of the new member ID's by posting notices on all the web sites, flyers in every local office, the EDS Provider Reps have educated Providers in every work shop conducted since the last quarter of '06, the FH staff are doing the same via phone calls.

As far as how providers use the cards, that part will not be changing. The only change will be that the Member's Medicaid ID number will no longer contain the SSN. This change will now adhere to HIPAA privacy and security.

What is the level of information members are receiving about changes in the Medicaid program? Members should be able to view changes in the Medicaid program by reviewing the DMS website and *KyHealth Choices*. DMS is also working with First Health on developing a member handbook that will be available online.